STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

[redacted]

PETITIONER,

vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 05 Hernando
UNIT: AHCA

RESPONDENT.
_____/

APPEAL NO. 15F-05931

FINAL ORDER

Pursuant to notice and agreement, Hearing Officer Patricia Antonucci convened an administrative hearing in the above-referenced matter on September 24, 2015 at approximately 1:00 p.m. All parties and witnesses appeared via teleconference.

APPEARANCES

For Petitioner: [redacted] Petitioner
[redacted] Petitioner's wife

For Respondent: Selwyn Gossett, Medical/Health Care Program Analyst, Agency for Health Care Administration

Bonnie Taylor, Program Administrator, Agency for Health Care Administration

ISSUE

At issue is whether Respondent, the Agency for Health Care Administration (AHCA or 'the Agency'), through its contracted Health Maintenance Organization, Sunshine Health, properly terminated provision of Petitioner's medical/wound care

supplies. Respondent bears the burden of proving, by a preponderance of the evidence, that this termination was proper.

PRELIMINARY STATEMENT

This matter was initially scheduled for telephonic hearing on August 26, 2015. Due to erroneous information received by the Office of Appeal Hearings, the August 26th hearing was cancelled. When Petitioner contacted the Office of Appeal Hearings to correct this information, the matter was set for a telephonic status conference on September 2, 2015 at 10:00 a.m.

All parties appeared, as scheduled, on September 2, 2015. At that time, it was determined that hearing based on certain items of durable medical equipment (DME) and wound care/consumable medical supplies (CMS) – collectively referenced as medical supplies (MS) – would convene on September 24, 2015 at 1:00 p.m. Although Sunshine had also advised Petitioner that additional wound care supplies (two types of AG patches and Medipore tape) might be terminated, Sunshine had yet to generate a Notice of Case Action for these items. As such, Petitioner was advised to await denial and request a separate hearing if the AG patches and Medipore tape were not approved.

Petitioner was present at hearing, and was represented by his wife, [redacted] Petitioner presented one witness: [redacted] Senior Human Services Program Specialist with AHCA. As Petitioner subpoenaed [redacted] as a witness, David Nam, Esq., also with AHCA, appeared to ensure [redacted] was not being questioned in her personal capacity.

AHCA Medical/Health Care Program Analyst, Selwyn Gossett, represented Respondent at the telephonic status conference and engaged in substantial correspondence with Petitioner regarding his appeal; however, at hearing on September 24, 2015, Mr. Gossett was unavailable. Respondent was represented by his supervisor, Bonnie Taylor. Pat Brooks and Ingrid Paige, also with AHCA, observed the final hearing. Respondent presented the following witnesses from Petitioner's Long Term Care (LTC) plan, Sunshine Health:

- □ Donna Melogy, Executive Director (status conference, only);
- □ John Carter, M.D., Medical Director;
- □ Jennifer Arteaga, Grievance and Appeals Coordinator;
- □ Donna Laber, R.N., Grievance and Appeals Manager;
- □ Tammi Swan, Case Manager Supervisor;
- □ Angela Blue, Case Manager; and
- □ Tiffany Smith, Grievance and Appeals Coordinator II (observed hearing).

Petitioner had no objection to the three noted individuals observing the proceedings. Petitioner's Exhibits 1 through 8, inclusive, and Respondent's Exhibits 1 through 3, inclusive, were accepted into evidence. The record was held open to receive from Respondent supplemental documentation referenced at hearing but not previously filed in the case, as well any response from Petitioner thereto. Respondent's supplement was timely received and confirmed received by Petitioner. It has been entered as follows:

- Respondent's Exhibit 4: single-page cover sheet + six pages of the AHCA, Attachment II Core Contract Provisions, effective April 15, 2015 (7 pages total).

FINDINGS OF FACT

Based on the oral and documentary evidence presented at the final hearing and on the entire record of this proceeding, the following Findings of Fact are made:

1. Petitioner is a 63-year-old male, born [redacted] He has multiple medical needs, which include wound care and home management of three separate wound sites. The Petitioner visits a wound care center approximately once every 2 weeks (if he is healthy enough to attend), but the center does not provide supplies for at-home use. Petitioner's wife provides in-home wound care every two days, for all three wounds.

2. The Petitioner was previously enrolled in a Medicaid Waiver Program, but transferred to Sunshine Health's LTC "Tango" Plan, with an effective enrollment date of March 1, 2014. AHCA contracts with Sunshine Health, a managed care/HMO company, to provide Long Term Care services to eligible Medicaid recipients. Petitioner also receives Medicare through a separate HMO, United Healthcare.

3. Upon enrollment with Sunshine, and in accordance with the requirements of their contract with AHCA, Petitioner's services continued, unaltered, until Sunshine conducted its own assessment of Petitioner's needs.

4. Sunshine conducted an assessment of Petitioner on or about January 30, 2015, and completed a care plan review in April of 2015. Per Petitioner's care plan, at least as early as April 27, 2015 (and noted as "ongoing"), he was authorized to receive monthly supplies of medical equipment including, but not limited to, these seven items:

- A6454, Co-band (self-adhesive): 31 units;
- A6402, 4x4 gauze: 200 units;

- A5120, Skin barrier/prep: 50 units;
- A6446, Self-conforming gauze: 31 units;
- A4216, Saline solution 10ML (sterile): 6 units;
- T5999, Cotton tip applicators: 1 box; and
- E0325, Male urinals: 2 units.

5. Via Notice of Case Action dated July 6, 2015, Sunshine informed Petitioner, in pertinent part:

> Sunshine Health has reviewed your request for Coban (self-adhesive bandage), 4x4 Gauze, Skin Barrier, Conforming Gauze, Sterile Saline, and Cotton Tipped Applications, which we received on 6/29/15. After our review, this service has been TERMINATED as of 7/16/15.
> ...
> We made our decision because:
> _X__ We determined that your requested services are **not medically necessary** because the services do not meet the reason(s) checked below: (See Rule 59G-1.010)
> ...
> _X__ **Other authority: Medicare is the primary payor.**
> **The wound care supplies: Coban (self-adhesive bandage), 4x4 Gauze, Skin Barrier, Conforming Gauze, Sterile Saline, and Cotton Tipped Applicators, have been terminated (stopped). Your Medicare policy is the primary payor for these items.**
> (emphasis original)

6. By a separate Notice of Case Action, also dated July 6, 2015, Sunshine informed the Petitioner that his male urinals would also be terminated, effective July 16, 2015, noting, "**You are getting Male Urinals, this has been terminated (stopped). Your Medicare policy is the primary payor for these items**," (emphasis original).

7. As Petitioner timely requested a hearing to challenge the termination of these seven medical supplies, Sunshine reinstated and has continued to supply the equipment, pending the outcome of this appeal.

8. On or about July 9, 2015, Sunshine completed an additional care plan review. Although the draft version of the care plan still lists the seven medical supplies in dispute, it is not clear whether Petitioner's case manager recommended continued authorization of same.

9. At hearing, Petitioner explained that he has requested certain supplies from Medicare, but has not requested coverage of all the medical supplies at issue. Petitioner did receive one denial letter from his Medicare HMO (United), on or about June 24, 2015. Said letter notes that Petitioner's request was denied as out-of-network, since the supplier he was using at the time (Prism) was not a participating provider.

10. In multiple attempts to coordinate his own care, Petitioner sought assistance from AHCA, the Department of Elder Affairs, Medicaid personnel, and his current MS supplier (Medline), regarding receipt of the supplies he needs. Petitioner was advised by Medline that Medicare would cover variations on some of the supplies; however, Petitioner has no further correspondence or denials from Medicare.

11. Sunshine argues that Petitioner must first request coverage of the MS from United, as Medicare is Petitioner's primary coverage provider. Sunshine does not specifically contend that the requested medical supplies are not necessary to treat Petitioner's wounds, nor does Sunshine contend that the supplies are non-covered items. It is Sunshine's position, however, that they will not authorize the supplies until they receive written notification from United as to what United/Medicare will and will not provide.

12. Mr. Gossett, on behalf of AHCA, argued that, per the Florida Medicaid Provider General Handbook (July 2012), Petitioner must submit all requests first to his Medicare

HMO. It was Mr. Gossett's position (per status conference and written correspondence with Petitioner) that Sunshine would not be required to provide medical supply coverage absent both a denial and an unsuccessful appeal from Petitioner's Medicare plan.

13. Ms. Taylor, on behalf of AHCA, posited that AHCA's contract with Sunshine LTC requires coordination of care. It was her position that Sunshine is responsible for providing case management and care coordination consistent with this contract. As such, she stated AHCA's position as requiring Sunshine to communicate with Petitioner's Medicare HMO to determine coverage of his medical supply needs.

CONCLUSIONS OF LAW

14. By agreement between AHCA and the Department of Children and Families, the Office of Appeal Hearings has jurisdiction to conduct this hearing pursuant to Florida Statutes Chapter 120.

15. Legal authority governing the Florida Medicaid Program is found in Florida Statutes, Chapter 409, and in Chapter 59G of the Florida Administrative Code. Respondent, AHCA, administers the Medicaid Program.

16. This is a Final Order, pursuant to § 120.569 and § 120.57, Fla. Stat.

17. This hearing was held as a *de novo* proceeding, in accordance with Fla. Admin. Code R. 65-2.056.

18. The burden of proof in the instant case is assigned to Respondent, who proposes to terminate medical supply coverage.

19. The standard of proof in an administrative hearing is "preponderance of the evidence." (See Fla. Admin. Code R. 65-2.060(1).)

20. Florida Statutes §409.905 addresses mandatory Medicaid services under the State Medicaid Plan, noting, in part:

> Mandatory Medicaid services.--The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law....
>
> (4) HOME HEALTH CARE SERVICES.—The agency shall pay for nursing and home health aide services, supplies, appliances, and durable medical equipment, necessary to assist a recipient living at home. An entity that provides such services must be licensed under part III of chapter 400. These services, equipment, and supplies, or reimbursement therefor, may be limited as provided in the General Appropriations Act and do not include services, equipment, or supplies provided to a person residing in a hospital or nursing facility. (emphasis added)

21. Also with regard to managed care, per Fla. Stat. § 409.965:

> All Medicaid recipients shall receive covered services through the statewide managed care program, except...The following Medicaid recipients are exempt from participation in the statewide managed care program:
> (1) Women who are eligible only for family planning services.
> (2) Women who are eligible only for breast and cervical cancer services.
> (3) Persons who are eligible for emergency Medicaid for aliens.

22. Fla. Stat. § 409.972 adds to the list of those exempt, noting:

> (1) The following Medicaid-eligible persons are exempt from mandatory managed care enrollment required by s. 409.965, and may voluntarily choose to participate in the managed medical assistance program:
> (a) Medicaid recipients who have other creditable health care coverage, excluding Medicare.
> (b) Medicaid recipients residing in residential commitment facilities operated through the Department of Juvenile Justice or mental health treatment facilities as defined by s. 394.455(32).
> (c) Persons eligible for refugee assistance.
> (d) Medicaid recipients who are residents of a developmental disability center, including Sunland Center in Marianna and Tacachale in Gainesville.

(e) Medicaid recipients enrolled in the home and community based services waiver pursuant to chapter 393, and Medicaid recipients waiting for waiver services.
(f) Medicaid recipients residing in a group home facility licensed under chapter 393.
(g) Children receiving services in a prescribed pediatric extended care center.
(2) Persons eligible for Medicaid but exempt from mandatory participation who do not choose to enroll in managed care shall be served in the Medicaid fee-for-service program as provided under part III of this chapter.
(3) The agency shall seek federal approval to require Medicaid recipients enrolled in managed care plans, as a condition of Medicaid eligibility, to pay the Medicaid program a share of the premium of $10 per month.

23. No evidence was presented to demonstrate that Petitioner may opt-out of managed care for his Long-Term Care needs.

24. Section 409.978, Florida Statutes, provides that the "Agency shall administer the long-term care managed care program," through the Department of Elder Affairs and through a managed care model. Fla. Stat. § 409.981(1), authorizes AHCA to bid for and utilize provider service networks to achieve this goal. In the instant case, the provider network/HMO is Sunshine Health.

25. Sunshine contends that its decision to terminate Petitioner's seven pieces of medical equipment is due not to the fact that they are not "medically necessary" to treat Petitioner's wounds, but rather, because Petitioner must first seek coverage of these supplies through his Medicare HMO. Although Sunshine's Notice references medical necessity, Sunshine did not rely upon this argument at hearing, nor contend that the items requested are uncovered items under Sunshine's LTC plan.

26. The July 2012 Florida Medicaid Provider General Handbook ("Provider General Handbook"), is incorporated into rule via Fla. Admin. Code R. 59G-5.020, as follows:

> All Medicaid providers enrolled in the Medicaid program and billing agents who submit claims to Medicaid on behalf of an enrolled Medicaid provider must comply with the provisions of the Florida Medicaid Provider General Handbook, July 2012…
> (emphasis added).

27. Per page 1-12 of the Provider General Handbook:

> Third Party Liability (TPL) is the obligation of any entity other than Medicaid or the recipient to pay all or part of the cost of the recipient's medical care. If the recipient has other coverage through a TPL source, the provider must bill the TPL source prior to billing Medicaid.
> …
> Florida Medicaid and Title 42, Code of Federal Regulations, Part, 447.20 (b), prohibit a provider from refusing to furnish a covered Medicaid service to a Medicaid recipient solely because of the presence of other insurance, including Medicare. Although providers can choose which Medicaid recipients they will serve, they cannot refuse services to recipients solely due to third party coverage.
> …
> **Responsibility For Exhausting TPL Sources**
> Medicaid is the payer of last resort. If a recipient has other insurance coverage through a third party source, such as Medicare, TRICARE, insurance plans, AARP plans, or automobile coverage, the provider must bill the primary insurer prior to billing Medicaid.
>
> If the amount of the third party payment meets or exceeds the Medicaid fee for the service, Medicaid will not reimburse for the service. If the third party payment amount is less than the Medicaid fee, Medicaid will reimburse the difference between the Medicaid fee and the third party payment minus any Medicaid copayment or coinsurance.
> (underline emphasis added)

28. This above-cited authority clearly sets forth a duty on behalf of the *provider* to bill/submit claims to Medicare before balance-billing to Medicaid. However, the authority does *not* specify that it is the responsibility of a Medicaid recipient/member to

request services from a Medicare HMO before requesting same from his Medicaid health plan.

29. According to AHCA's LTC plan contract with Sunshine Health (see AHCA, Attachment II Core Contract Provisions, Effective 11/15, page 90 of 214)[1]:

> Managing Mixed Services
> a. The Managed Care Plan shall provide case management and care coordination with other Managed Care Plans for enrollees with both MMA benefits and LTC benefits to ensure mixed services are not duplicative but rather support the enrollee in an efficient and effective manner. When a recipient is enrolled in both the LTC and MMA programs, the LTC case manager is primarily responsible for care coordination and case management to enrollees. LTC Managed Care Plans shall provide mixed services to enrollees with LTC benefits, regardless of an enrollee's enrollment in an MMA Managed Care Plan.
> ...
> b. Managed Care Plans shall coordinate with any other third party payor sources to ensure mixed services are not duplicative.
>
> (emphasis added)

30. Page 13 of 90 of the AHCA model contract, Attachment II, Exibit II-B, Effective 11/1/15 lists the descriptions for required LTC case management, noting:

> Care Coordination/Case Management — Services that assist enrollees in gaining access to needed waiver and other State plan services, as well as other needed medical, social, and educational services, regardless of the funding source for the services to which access is gained. Case management services contribute to the coordination and integration of care delivery through the ongoing monitoring of service provision as prescribed in each enrollee's plan of care.
> (emphasis added)

31. Although it is acknowledged that Petitioner's Medicare plan, United, may indeed be the payor of first resort, Sunshine initially authorized Petitioner's medical supplies as medically necessary. As Sunshine now seeks to terminate what it previously

[1] This corresponds to page 92 of 220 of the AHCA contract, effective April 15, 2015, which was entered as Respondent's Composite Exhibit 4.

authorized, Sunshine bears the burden of proving that its decision to terminate Petitioner's medical supplies is proper. Absent verification that United *will* cover the seven items at issue, and absent evidence to show that Sunshine has diligently attempted to coordinate this care with United, as required by its contract with AHCA, Sunshine cannot meet this burden.

32. Petitioner is cautioned that the undersigned makes no determination with regard to future requests for services or items, for which *Petitioner* might bear the burden of proof. As such, Petitioner is encouraged to keep in contact with his Sunshine case manager and request coordination of benefits, as needed.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, Petitioner's appeal is hereby GRANTED.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the agency has no funds to assist in this review.

DONE and ORDERED this 30 day of November, 2015,

in Tallahassee, Florida.

Patricia C. Antonucci
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: appeal.hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
Debbie Stokes, Area 4, AHCA Field Office Manager